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ABSTRACT

In December 2001, Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) brought together representatives of 17 advocacy groups who are concerned about the provision of positive behavioral supports and mental health services for students with significant social, behavioral and/or emotional needs. The agenda for this group included: a discussion of the upcoming reauthorization of the Individuals with Disabilities Education Act Amendments of 1997 (IDEA '97), and a discussion of the connection of mental health services and special education. After reviewing the available scientific evidence and professional literature, this group concluded that many of the provisions of IDEA '97 have yet to be fully implemented for children and youth with disabilities. Particularly at risk of not receiving needed instructional and related services are those youth who are significantly impacted by social, emotional, and/or behavioral problems, including children with significant mental health needs. As a result of this review, members of the group have produced this document to provide an overview of the status of the implementation of IDEA, with a special focus on students with disabilities who have significant social, emotional and/or behavioral needs, including those with early-onset mental illnesses. This document highlights the unmet educational needs of these youth, as well as the potential benefits to schools, children and families of improving the educational outcomes for these children and youth by reinvesting in and strengthening IDEA implementation. (Contains 39 references.) (GCP)

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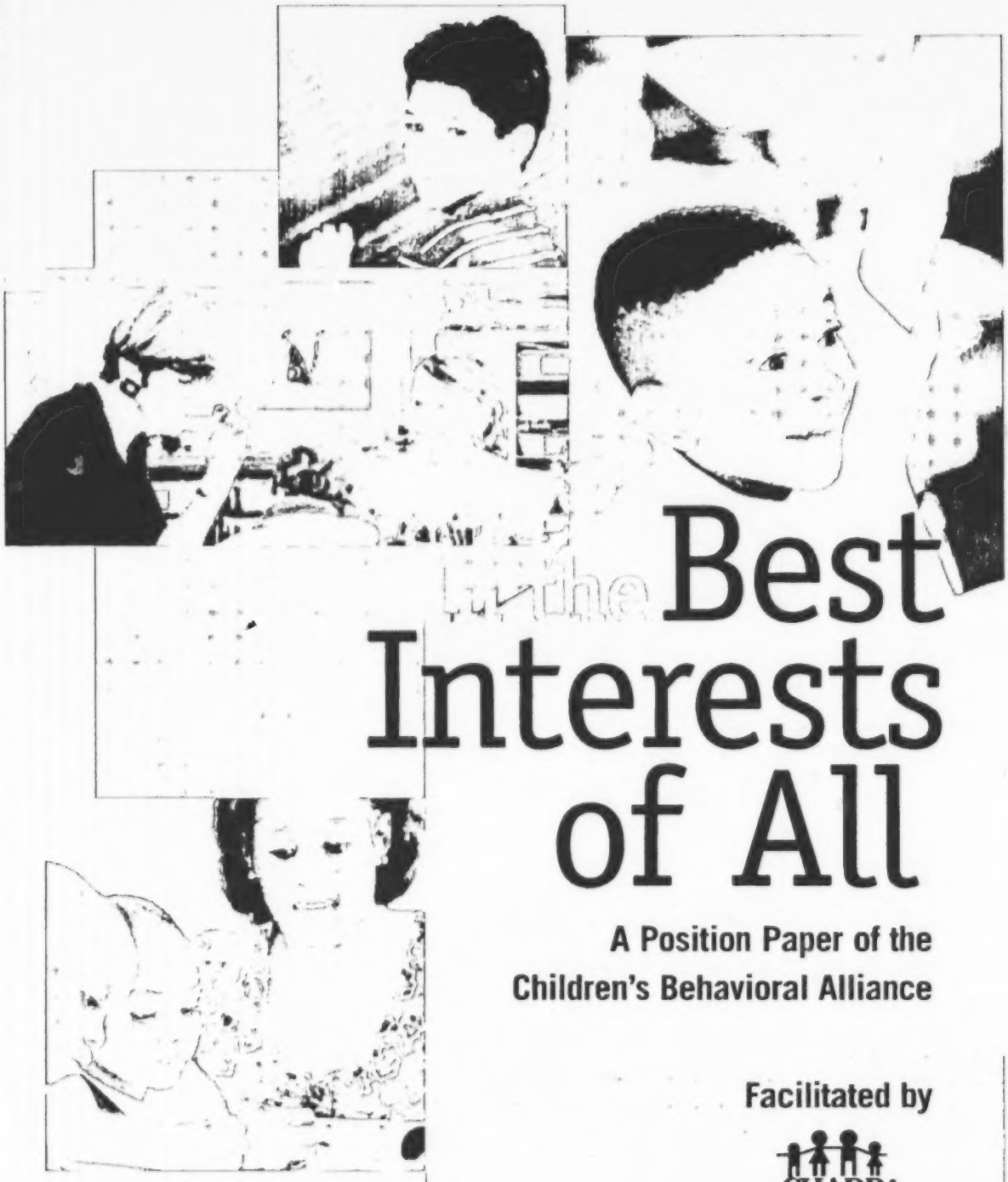

In the Best Interests of All

A Position Paper of the Children's Behavioral Alliance

Facilitated by

CHADD
CHILDREN & ADULTS WITH ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER

January 2003

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School Social Work Association of America
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In the Best Interests of All

A Position Paper of the Children's Behavioral Alliance

Executive Summary

In December 2001, a group of concerned parents and professionals representing 17 advocacy organizations met to share their mutual beliefs and concerns regarding the positive behavioral support needs of students with significant social, emotional, and/or behavioral differences. After reviewing the available scientific evidence and professional literature, this group concluded that many of the provisions of the Individuals with Disabilities Education Act Amendments of 1997 (IDEA '97) have yet to be fully implemented for children and youth with disabilities (Smith, 2000; Yell et al., 2000), and failing to do so continues to stand in the way of every child receiving a first-class education in America. Particularly at risk of not receiving needed instructional and related services are those youth who are significantly impacted by social, emotional, and/or behavioral problems, including children with significant mental health needs.

Of all the populations of students served in our schools, children with disabilities who also have significant social, emotional, and/or behavioral needs, including those with early-onset mental illnesses, pose the greatest challenges for educators and other service providers. These children, who represent 11% of our nation's youth (Office of the Surgeon General, 1999), exhibit complex problems that manifest in most environments in which students function. Without effective interventions, these problems predispose students to long-term negative outcomes, including vocational and mental health problems as adults and increased risks for incarceration (Office of the Surgeon General, 1999). These are often the children who are shuffled from system to system without having their educational needs adequately assessed or addressed. School personnel frequently are not trained to recognize the problems of these children, while schools and other care-taking institutions, may not have the resources to address children's behavioral and mental health needs.

The challenges that educators, parents, and other service providers face in meeting the needs of these students are numerous. The lack of well-trained personnel and comprehensive and sustained services, insufficient funding, definitional obstacles, and short-sighted responses to problems all combine to make providing preventive, therapeutic, or restorative services to children and families a difficult task under the best of circumstances. A recent report from the U.S. Surgeon General (2000) revealed that fewer than 1 in 4 students with significant emotional and behavioral disorders are receiving minimally adequate treatment, both in school and elsewhere.

While research advances are making better outcomes possible (Office of the Surgeon General, 1999) for children with significant emotional, behavioral, and/or learning problems, potential cutbacks in provisions of IDEA or school-based mental health resources will likely have tragic consequences, particularly given the many current barriers to identification and treatment. Such cutbacks will also have a signifi-

cant impact on schools, which are expected to achieve ever higher academic results with increasingly heterogeneous populations of students, many of whom have significant language, learning, and behavioral problems (U.S. General Accounting Office, 2001).

We believe that the application of positive behavioral supports for all students (Sugai et al., 2000), including those posing substantial behavioral challenges, will contribute significantly to improving the academic achievement of all students. This conclusion is supported by recent work from the Center on Positive Behavioral Intervention and Supports (Horner & Sugai, 2002). Restrictions in IDEA eligibility could compromise already scarce resources available to children with Emotional Disturbance, Other Health Impaired, and/or other significant health-related needs. ***Instead, improved and enhanced services within IDEA and better linkages to other school-based, community mental health, primary care, and community-based resources are a much more appropriate solution — one urgently needed.***

Considering this body of research and keeping family and student in mind, the Children's Behavioral Alliance advocates the following legislative agenda:

I. **Ensure that children with social, emotional, and/or behavioral problems remain covered by existing eligibility categories within IDEA.**
II. **Maintain IDEA '97 requirements that provide children with disabilities who also have social, emotional, and/or behavioral needs with positive behavioral intervention and support including use of Functional Behavioral Assessment and Behavior Intervention Programs.**
III. **Amend IDEA to ensure that Functional Behavioral Assessments and Behavior Intervention Plans, and School-Wide Positive Behavioral Supports are used preventively in response to social, emotional, and/or behavioral problems that have not diminished through the use of standard intervention practices.**
IV. **Maintain the existing IDEA '97 requirement for no cessation of services for children with disabilities.**
V. **Amend the Elementary and Secondary Education Act to extend the "no cessation of services" requirement to all students and to require provision of positive behavioral supports to address problem behaviors.**
VI. **Maintain existing IDEA requirements in relation to manifestation determinations and transfer to interim alternative educational settings.**
VII. **Maintain the existing IDEA '97 categories of students who can be placed in Alternative Educational Programs for 45 days.**
VIII. **Fully fund IDEA at the 40% federal level originally promised by Congress.**
IX. **Maintain non-supplanting provisions to ensure that increased federal funds for special education are used appropriately rather than redirected to general education funding at state and local levels.**
X. **Implement procedures consistent with the 2000 National Council on Disability report, Back to School on Civil Rights, to assure meaningful monitoring and compliance with and enforcement of IDEA.**
XI. **Require periodic behavioral/mental health screening of all children.**

XII. Expand IDEA Part D professional development requirements to ensure that all educational and related services staff receive training in positive behavioral supports, functional behavioral assessments, and behavioral intervention planning, and to assure availability within all districts of support staff with more intensive training in such strategies.

XIII. Amend IDEA to include the "fully-qualified teacher" provisions and timelines of the No Child Left Behind Act of 2001 in IDEA and apply them to special educators.

XIV. Increase funding for integrated services among schools, juvenile courts, child welfare, community mental health providers, primary care providers, public recreation agencies, and community-based organizations, and tie increases in federal funding to coordinated models of service delivery.

XV. Increase federal funding for research and training of educators, mental health professionals and parents to improve interagency cooperation and parent involvement.

IDEA '97 laid the groundwork for the delivery of meaningful services to children with disabilities who also have significant social, emotional, and/or behavioral needs. The members of the Children's Behavioral Alliance strongly believe that the provisions of IDEA '97 have not been fully implemented for these children and their families. The implementation of these provisions, with integrity, is essential in fulfilling the promise that every child receives a first-class education in America. IDEA '97 was an important step in the right direction, but more needs to be done to ensure that schools, communities and families work in effective partnerships to meet the needs of these children who often have misunderstood and underestimated disabilities.

References

Horner, R. & Sugai, G. (2002, February). *Beyond Classroom Management: Implementing School-wide Positive Behavior Supports.* (Paper presented at the Conference on Prevention of School Violence and Delinquency for the National Center on Education, Disabilities, and Juvenile Justice, Des Moines, Iowa).

Office of the Surgeon General. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Office of the Surgeon General. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, D.C.: Department of Health and Human Services.

Smith, C. R. (2000). Behavioral and discipline provisions of IDEA '97: Implicit competencies yet to be confirmed. *Exceptional Children*, 66, 403-412.

Sugai, G., Horner, R.H., Dunlap, G., Hieneman, M. Lewis, T.J., Nelson, C.M., Scott, T., Liaupsin, C., Sailor, W., Turnbull, A.P., Turnbull, H.R., III, Wickham, D., Reuf, M., & Wilcox., B. (2000). Applying positive behavioral support and functional behavioral assessment in schools. *Journal of Positive Behavioral Interventions*, 2, 131-143.

U.S. General Accounting Office. (2001). Report to the Committees on Appropriations, U.S. Senate and House of Representatives: Student Discipline, Individuals with Disabilities Education Act (GAO-01-210). Washington, DC: U.S. Government Printing Office.

Yell, M. L., Katsiyannis, A., Bradley, R. & Rozalksi, M. (2000). Ensuring compliance with the discipline provisions of IDEA '97: Challenges and opportunities. *The Journal of Special Education Leadership*, 13, 3-18.

In the Best Interests of All

A Position Paper of the Children's Behavioral Alliance

Introduction

In December 2001, CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder) brought together representatives of 17 advocacy groups who are concerned about the provision of positive behavioral supports and mental health services for students with significant social, behavioral and/or emotional needs. The agenda for this group included:

- A discussion of the upcoming reauthorization of the Individuals with Disabilities Education Act Amendments of 1997 (IDEA '97), with an emphasis on the existing provisions in relation to behavior and discipline, and
- A discussion of the connection of mental health services and special education, including efforts needed to improve early intervention and the ongoing provision of evidence-based mental health services for children and youth.

After reviewing the available scientific evidence and professional literature, this group concluded that many of the provisions of IDEA '97 have yet to be fully implemented for children and youth with disabilities (Smith, 2000; Yell et al., 2000), and failing to do so prevents every child from receiving a first-class education in America. Particularly at risk of not receiving needed instructional and related services are those youth who are significantly impacted by social, emotional, and/or behavioral problems, including children with significant mental health needs. To assure that these children receive the education they deserve, we must ensure that school personnel understand and address the needs of students with mental and behavioral health needs and involve families and caregivers in meaningful ways.

As a result of this review, members of the group (referred to hereafter as the Children's Behavioral Alliance, or CBA) have produced this document to provide an overview of the status of the implementation of IDEA, with a special focus on students with disabilities who have significant social, emotional and/or behavioral needs, including those with early-onset mental illnesses. This document highlights the unmet educational needs of these youth, as well as the potential benefits to schools, children and families of improving the educational outcomes for these children and youth by reinvesting in and strengthening IDEA implementation.*

* All members of the CBA had significant input into the drafting of this document, and the initial draft was edited by a committee representing the major disciplines within the CBA. The primary authors of the Paper are Carl Smith, Ph.D., of the Resource Center for Issues in Special Education at Drake University in Des Moines, IA; Peter Jensen, M.D., of the Center for the Advancement of Children's Mental Health at Columbia University in New York, NY; Matthew Cohen, J.D., of Monahan and Cohen, Attorneys at Law, in Chicago, IL; and Brenda Scheuermann, Ph.D., of the Special Education Program at Southwest Texas State University in San Marcos, TX.

Background

Of the various populations of students served in our schools, children with disabilities who have significant social, emotional, and/or behavioral needs pose the greatest challenges for educators and other service providers. These children, who represent 11% of our nation's youth (Office of the Surgeon General, 1999), exhibit complex problems that manifest in most environments in which students function. Without effective interventions, these problems predispose students to long-term negative outcomes, including vocational and mental health problems as adults and increased risks for incarceration (Office of the Surgeon General, 1999). These often are the children who are shuffled from system to system without having their educational needs adequately assessed or addressed. School personnel frequently are not trained to recognize the problems of these children, and schools, as well as other care-taking institutions, may not have the resources to address children's behavioral and mental health needs. These problems can even be associated with fatal outcomes. For example, suicide, a concomitant of depression, is one of the leading causes of death in adolescents — only behind accidents and homicide (Office of the Surgeon General, 1999) — and is responsible for more deaths in this age group than all other illnesses combined.

Research has shown that many of these students present complex problems that require sustained and well-coordinated services from agencies of multiple disciplines, including schools, mental health, pediatrics, social services, and intensive case management. Perhaps most importantly, appropriate and well-planned special education programs and services are essential. The degree to which these services are available is directly correlated with both short- and long-term prognosis. Fewer services, provided in a haphazard fashion, translate to poor outcomes for these children, both immediate and distant (e.g., school failure, incarceration, substance abuse) (Office of the Surgeon General, 1999; MTA Cooperative Group, 1999).

For the purposes of this paper, we will focus on the educational needs of these youth. Other efforts (Osher et al., 1994; U.S. Department of Education, 1994) have addressed the need for a broad national agenda that best serves these youth. On an individualized program level, these youth require programs and services that are based on the following principles:

- Appropriate and comprehensive assessment of the students who are the focus of our concerns, including regular and special education environments, as well as other environments in which they are being served.
- Comprehensive early screening of all students for emotional and behavioral difficulties.
- Intensive early intervention efforts that focus on prevention of more serious behavioral problems.
- Comprehensive interventions that are carefully matched to the needs of individual students.
- Intervention strategies that are evidence-based and continually monitored for effectiveness.
- Educational programs in which parents play an active and continuous role.

Unfortunately, as documented in the following pages, many of the programs for children and youth who are eligible for services under IDEA and have significant behavioral needs have not been fully implemented. These programs warrant priority consideration if we are to assure appropriate learning

outcomes for these youth. The good news is that we know what works to improve outcomes for many of these children. A substantial research base has documented the effectiveness of early intervention, sustained and comprehensive treatment services, and high-quality educational services that emphasize prevention. Thus, the long process of discovering effective treatments is well underway. Changes in policy are needed in order to implement effective practices to scale.

Some of the most recent advances in our knowledge of the needs of students with emotional and behavioral disturbances (EBD) relates to the role of instructional variables. Research has clearly demonstrated the reciprocal relationship between academic and behavioral problems. Academic failure increases risk for behavioral problems (Hallenbeck & Kauffman, 1995). Furthermore, classes for students with EBD that emphasize high academic expectations, meaningful instruction, and high levels of academic engagement typically are associated with fewer behavior problems than classes that have low-level expectations for learning. However, students with EBD historically have not fared well in terms of academic achievement. For example, the U.S. Department of Education's *Twentieth Annual Report to Congress (1998)* reported that students labeled Emotionally Disturbed (ED):

- Have the lowest grade-point average of any group of students with disabilities
- Fail more courses than any other group of students
- Are retained more than any other group of students
- Have the highest rate of absenteeism of any group of students
- Are more likely to drop out of school than any other groups of students (over 55% of students labeled ED drop out)

Teaching students with emotional and behavioral needs is a challenging task under the best of circumstances, even for the most experienced teacher. It is essential, however, for students with significant social, emotional and/or behavioral needs, including those with early-onset mental illnesses, to receive high-quality academic instruction for two reasons. First, these students typically have significant learning problems as well as behavior problems (Kauffman, 1997), with learning characteristics similar to those of students with learning disabilities (Scruggs & Mastropieri, 1986). Second, behavior is inseparably linked to the instructional environment. Instruction that is lacking or weak, or curriculum that is irrelevant or inappropriate for students' needs may be antecedents for inappropriate behaviors. Conversely, research has shown that inappropriate behavior can be reduced by providing an effective and instructionally rich environment (Munk & Repp, 1994). Thus, perhaps the most effective behavior management tool is high-quality instruction in relevant curriculum. Research has delineated instructional methods that, when applied with fidelity, have a high probability of producing desired learning outcomes for students with EBD (Lloyd et al., 1998). Higher levels of student achievement and fewer behavior problems can be expected when teachers rely on these methods to teach skill-appropriate and pertinent curricula.

One of the most critical areas to be addressed legislatively with respect to improving outcomes for students with EBD is ensuring that all students with EBD are taught by teachers who have sufficient and appropriate training. Unfortunately, given current shortages of qualified special education teachers, these most difficult-to-teach students are too often taught by under-prepared teachers. Even teachers who meet state standards for special education certification may not possess the knowledge and skills needed to effectively educate these students. For example, more and more states are moving to generic certification requirements, which may not cover the specialized skills needed by teachers of students with EBD.

In an effort to address ubiquitous teacher shortages, many states offer expedited routes to special education certification, such as alternative certification programs or testing for certification. Alternative certification programs allow teachers to obtain certification after completing an abbreviated course of training and a one-year internship during which the participant is the teacher of record in a special education class. Testing for certification means that any teacher holding state certification in any area of teaching may take the certification test for special education. A passing score on that test means the individual is then "qualified" to teach special education by state standards, without ever having any formal training or experience.

In short, research shows that a critical variable in the prognosis for students with EBD is the quality of the educational program. Well-trained teachers who can plan and implement meaningful, dynamic programs with appropriate instructional and behavioral priorities are critical to the educational success of these students.

Best Practices and What We Know about Current Programs and Services

Screening, Assessment, and Diagnosis

The last decade has witnessed substantial advances in our ability to accurately screen, identify, and assess children with significant learning, emotional and/or behavioral needs. New tools have been developed and subjected to rigorous studies of their reliability and validity. Currently, a well-established diagnostic system, known as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (1994), has been made widely available and is used throughout the United States and most of the Western world. Every major learning, emotional, and behavior disorder that affects adults has been shown to affect children and adolescents. Such conditions include major depressive disorder, panic disorder, bipolar disorder, agoraphobia, obsessive-compulsive disorder, generalized anxiety disorder, and schizophrenia. Several conditions particularly affect children and in fact, begin in childhood, such as attention-deficit/hyperactivity disorder (AD/HD), learning disabilities, Tourette syndrome, and autism. While physicians and scientists used to believe that such conditions were either milder or did not affect children at all, it is now known that such conditions beginning in childhood may actually be more severe than the adult-onset counterparts of these disorders.

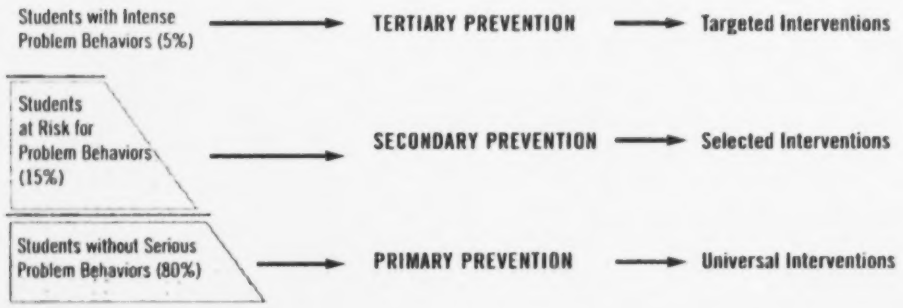
Despite the recent availability of tools to aid in the assessment and diagnosis of such conditions, estimates compiled by the Office of the Surgeon General (1999) indicate that only 1 in 4 of children with mental or emotional disorder is in fact receiving any treatment (Burns et al., 1995; Leaf et al., 1996). Worse still, despite the provisions of IDEA, the under-recognition problem is especially pronounced in school settings. For example, despite national estimates of 5% of children meeting criteria for *severe* impairment due to mental illness (Office of the Surgeon General, 1999), state classification rates of children with behavioral and emotional disturbances have been reported to vary as much as 50-fold (Danielson et al., in press), differences that are principally explained by state-wide variations in school financial and training resources to identify and intervene with these children.

Difficulties in supporting adequate diagnostic procedures persist because in-depth diagnostic procedures often require resources that schools may not have. Yet without an accurate diagnosis, specific and effective school-based interventions for conditions such as major depressive disorder, bipolar disorder, learning disability, and AD/HD may not be delivered, despite data indicating that provision of such high

quality, school-based services is associated with better outcomes (MTA Cooperative Group, 1999). The accurate identification of these various medical-psychiatric conditions is often critical in determining the specific focus of special education services that should be provided to individual students (Forness & Kavale, 2001).

School-based Interventions

According to Walker and Sprague (1999), approximately 80% of students do not exhibit serious behavioral or emotional problems. A small percentage of students (~15%) are at risk for problem behaviors and an even smaller percentage (~5%) actually have chronic/intense problem behavior. These figures emphasize the need for a more proactive and comprehensive approach as illustrated by Walker and Sprague in the 3-tier model depicted below:



Children who fall in the middle category are at increased risk for further difficulties, and often go on to more severe problems if appropriate assistance is not provided. Likewise, children in the lowest risk category (80% bottom of the pyramid) frequently move into higher levels of risk if the overall school environment is highly stressed. Thus, the most comprehensive and effective approach to assisting the 5% of children with the greatest level of need is to actually put into place school-wide programs that help educators enhance the overall learning environment for all students. Such programs, known as Positive Behavioral Interventions & Supports (PBIS), have been shown to reduce overall levels of aggression and bullying and thus improve the broader academic climate. Thus, this model emphasizes the need for prevention efforts at several levels of intensity in schools and other care-giving institutions. By implementing interventions at each of these levels, schools can maximize their ability to both effectively meet the needs of students who display these behaviors and prevent the development of more serious problem behaviors.

IDEA provisions generally address children in the top tier (5%) while other programs must be in place to provide more general assistance to schools. Existing interventions differ in the extent to which they address the multiple levels of the Walker and Sprague model. Hunter (2002) recently drew upon federal, state, and academic information sources to identify and review all programs that have been previously evaluated for each of these three levels. According to the Hunter review, multiple programs with substantial empirical support were identified at each of the three levels, but little systematic implementation of programs at any of the three levels has taken place. Such findings indicate a great opportunity to

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increase the level of school and teacher support to provide for training and implementation of these effective programs nationwide (Hunter, 2002; Office of the Surgeon General, 1999).

An Example of a Successful Program

To illustrate the promise of a well-executed and appropriately resourced program and its impact on children's lives, the National Institute of Mental Health (NIMH), with support from the U.S. Department of Education and the Office of Juvenile Justice and Delinquency Prevention, conducted a multi-site intervention across the United States and Canada, testing the benefits and impact of a well-executed program for children with AD/HD. This program, which included careful coordination between parents, teachers, and physician, additional support and consultation for classroom teachers, parental support, and closely managed medication, resulted in *almost complete abatement* of most children's AD/HD symptoms and substantial differences in children's overall outcomes 14 months later. This includes improved school deportment, increased parent and teacher satisfaction, increased peer acceptance, improved academic achievement, decreased emotional symptoms, and better parent-child relations, compared to children who received standard care in the community, usually medication without the additional school and home-based resources. The success of this program illustrates the promise of full implementation of IDEA.

Failing to address problems early on—and before they become severe—with the 15% of students at risk (middle category), such as by early screening and intervention programs or even through school-wide interventions such as PBIS programs, results in increased problems at all levels of the pyramid. School-wide programs that do not implement effective classroom behavior management strategies, discourage bullying, or ensure playground safety, not only increase the level of behavior problems in some children, but can also worsen conditions like anxiety, depression, and AD/HD and lead to other problems, such as school failure, learning problems, absenteeism, and early dropout. Unaddressed, such problems can be expected to affect the learning and behavior of children across an entire school.

Future Prospects: Promising or Problematic?

While research advances are making better outcomes possible (Office of the Surgeon General, 1999) for children with significant emotional, behavioral, and/or learning problems, potential cutbacks in provisions of IDEA or school-based mental health resources for these children will likely have tragic consequences, particularly given the many current barriers to identification and treatment. Such cutbacks will have a significant impact on schools, which are expected to achieve ever higher academic results with increasingly diverse populations of students, many of whom have significant language, learning, and behavioral problems (U.S. General Accounting Office, 2001).

We believe, based on a large body of research, that the application of positive behavioral supports for all students, including those posing severe behavioral challenges, will contribute significantly to better educational outcomes for *all students*. This conclusion is supported by recent work from the Center on Positive Behavioral Interventions and Supports (Horner et al., 2001). *Thus, the Children's Behavioral Alliance encourages improved and enhanced services within IDEA, better linkages to other school-based and community mental health, primary care, and community-based resources, and the application of best practices in behavior management and discipline to all students in schools. To this end, the CBA offers this summary of what is known about effective practices for students with emotional and behavioral needs. Furthermore, in this*

paper we make recommendations for legislative and policy changes that will help improve outcomes for all children, and especially for children with significant social, emotional, and/or behavioral needs.

Toward a More Rational, Equitable, and Effective Behavioral Support System: Strengthening Commitment and Building Capacity

IDEA '97 introduced a number of important requirements designed to improve positive services for children with disabilities who were experiencing social, emotional, and/or behavioral problems at school. It also adopted a number of procedural safeguards that are important to ensuring that schools make informed and effective responses to disciplinary problems. We believe that the services and safeguards contained in IDEA '97 need to be strengthened and enhanced to allow schools to respond more effectively to the behavior problems of children with disabilities. Ultimately, we believe that the services provided on behalf of children with disabilities with social, emotional, and/or behavioral problems are worthwhile for all children displaying behavioral problems, even those who are not currently eligible for special education services. We have included legislative changes and administrative recommendations.

In the second grade, our son's school recognized that his diagnosis of AD/HD truly did classify him for the "otherwise health impaired" category and went a step further by writing an IEP even though he technically did not meet the criteria. His principal attended the post assessment meeting and said, "We need to offer Joel any and all assistance to help him succeed and to protect his self esteem." Joel is currently in the seventh grade and consistently making As and Bs on his report card. I attribute his success equally to Joel's determination and his elementary school's foresight in understanding how early intervention would best serve his success then, and more importantly, in the future.

Early and Accurate Assessment

Schools are a critical first line of identification for children who are at risk for or are experiencing serious problems arising from social, emotional, and/or behavioral problems. For many children with disabilities, the school setting is especially challenging and may trigger behavioral issues warranting intervention. Unfortunately, some schools are ill equipped to provide early identification of children at risk or they provide limited screening and evaluation, thus often either failing to identify, overidentifying, or underidentifying children with disabilities who have social, emotional, and/or behavioral needs. Limited training, coupled with time and budgetary constraints, further impedes the ability of schools to engage in comprehensive, accurate assessments of children.

Legislation: Require periodic behavioral/mental health screening of all children.

Recommendation: Improve quality and quantity of training for school staff on early identification, pre-referral and referral procedures for students at risk for social, emotional and/or behavioral problems through enhanced staff preparation and in-service training programs.

Recommendation: Develop and implement models of assessment and intervention by qualified mental health professionals for children suspected of having more severe behavioral/mental health issues.

Recommendation: Develop and disseminate protocols for integrated school/community evaluation, including assessment of the need for at-home interventions to support the child and family.

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Better Training in Evidence-Based Practices for All Educators

We believe that IDEA '97 provided important steps towards achieving appropriate services for children with disabilities who have social, emotional and/or behavioral needs, including those with early-onset mental illnesses. Within the mental health and educational fields, much is already known and well researched about effective intervention strategies for children with these issues. Unfortunately, there is a wide gap between the knowledge on best practices and the capacity of schools and local mental health systems to work effectively and in a coordinated fashion to implement them. Much work needs to be done to enable our schools and other providers to provide the level of services needed by children with social, emotional and/or behavioral needs.

Legislation: Expand IDEA Part D personnel development requirements to ensure that all educational and related service staff receive training in school-wide positive behavioral interventions and supports, functional behavioral analysis and behavior intervention planning, and to assure availability within all districts of support staff with more intensive training in these techniques.

Legislation: Amend IDEA to include the "fully-qualified teacher" provisions and timelines of the No Child Left Behind Act of 2001 in IDEA and apply them to special educators.

Recommendation: Improve quality and quantity of training for school staff on early identification, pre-referral and referral procedures for students at risk for social, emotional and/or behavioral problems through enhanced staff preparation and in-service training programs.

Increased Collaboration Between Special and Regular Education and Between Schools and Other Public Agencies

Effective treatment of the social, emotional, and/or behavioral problems of children with disabilities cannot occur in a vacuum or for only a portion of the school day. Rather, intervention must address all domains in which the child functions, including school, home, and community. Stressors from each setting are likely to have a significant impact on the child's ability to function in other settings. It is critical that children receive coordinated services designed to provide structure and support in all areas of difficulty. For various reasons, many children are increasingly at home or in the community without supervision from their parents or other responsible adults. Simultaneously, some parents find it difficult to deal with the increasingly challenging behavior of their troubled children.

> My child's therapist works hand in hand with our school and vice versa. If Holly ditches a class, her therapist usually knows before I do and is able to address the underlying issues. Also, we have received transitional behavioral services, in which a behavioral specialist comes into the home to work with the family. This person at one point, was coming in the mornings to assist me in getting Holly to go to school. Our district works with Big Brothers/Big Sisters, bringing mentors into the schools to work with at-risk students. They come in once a week and the child leaves a class to have lunch, socialize, play games, etc. Holly is also involved with equine therapy for free through the non-profit group, Horses for Self Esteem, and our county mental health department has a monthly parent support group through United Advocates for Children of California.

In many areas, there is insufficient coordination between the various providers of support services to children with social, emotional, and/or behavioral needs. This leads to duplication of effort and fragmented services, ultimately undermining the efficacy of the individual services being provided to a child or family. Existing models of effective interagency cooperation, including pilot programs funded under the Comprehensive Community Mental Health Services for Children and their Families program, have produced improved outcomes for children with mental health needs. We must recognize that schools are the primary point of contact for

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children other than their families. As such, we must give schools the necessary support—through improved sharing of resources and responsibilities—to deliver more coordinated services.

Legislation: Increase funding for integrated services among schools, juvenile courts, child welfare, community mental health providers, primary care providers, public recreation agencies, and community-based organizations, and tie increases in federal funding to coordinated models of service delivery.

Recommendation: Improve interagency coordination as a critical step in more effectively utilizing existing resources by disseminating existing best practice interagency service models to all schools and community-based, federally-funded mental health and human services providers.

Legislation: Increase federal funding for research and training of educators, mental health professionals and parents to improve interagency cooperation and parent involvement.

Develop community and school-wide prevention strategies

It is well recognized that the most important mental health interventions involve prevention and early intervention. These strategies require the implementation of multi-tier system-wide procedures for addressing the needs of children at risk for social, emotional and/or behavioral problems, including community and school-wide procedures for early identification and referral; community and school-wide systems for teaching and promoting mental health and positive behavior; strategies that provide group-based reinforcement for appropriate behavior, and strategies for intervening and responding in a more individualized and intense manner in response to the needs of children with more severe problems. Such strategies should be utilized throughout the year, ensuring that children continue to receive services during the summer.

> The "no out of school suspension" policy at A. Quinn Jones Center has been a godsend for our families. Disciplinary interventions are handled by the school and at the school, enabling our children to remain in an educational setting and to learn rather than roam the streets and lose ground. This relieves the parents and caretakers during school hours, so that they can maintain their jobs and livelihoods, and reduces tension and stress at home. Children with behavioral problems are too often in a cycle of being behind at school, acting out because of it, being removed from school, becoming further behind...and starting all over again. Engaging these minds in learning is key to helping them achieve success.

IDEA '97 explicitly required school districts to utilize positive behavioral interventions and supports to address the behavioral problems of children with disabilities. Embedded in these requirements was also a requirement that children who were having behavioral problems of sufficient severity that lead to suspension in excess of ten school days should be evaluated using a functional behavioral assessment (FBA), a structured method for assessing the causes of behavioral difficulties. The FBA then provides the basis for the development of a behavioral intervention plan, which is to be developed through the Individualized Education Program (IEP) process and incorporated as part of the IEP. Unfortunately, although PBIS, FBA, and Behavior Intervention Planning have been recognized in the field for decades, many schools have limited experience in using them. IDEA '97 mandated that schools adopt PBIS-based practices, and although schools where this is occurring are showing positive results, there has been insufficient time to allow these procedures to be widely disseminated and implemented on scale (Conroy et al., 2002; Reid & Nelson, 2002). More time is needed to fully inform all educators about PBIS and to allow all schools to plan and implement PBIS-based school-wide systems.

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Legislation: Amend IDEA to ensure that functional behavioral analyses and behavior intervention plans and school-wide positive behavioral supports are implemented before social, emotional, and/or behavioral problems that have not diminished through the use of standard intervention practices occur.

Legislation: Expand IDEA Part D to allow greater technical assistance to schools in the area of PBIS and to increase best-practice prevention, early intervention, and collaborative interagency service models.

Recommendation: Require schools, in conjunction with local mental health, primary care, and child welfare providers, public recreation agencies, and community-based organizations, to provide after-school programming, in-home intervention and wrap-around and crisis management services to address the needs of children whose behavioral problems manifest themselves across settings.

Recommendation: Develop, fund and implement regional crisis evaluation/crisis intervention teams to assist children with severe social, emotional, and/or behavioral issues, where the presenting problems are beyond the ability of the local school and other providers.

Legislation: Increase federal funding for research and training of educators, mental health professionals and parents services on interagency cooperation and parent involvement.

Increased Intervention, Not Exclusion

Ensure continued coverage of children with social, emotional, and/or behavioral problems

IDEA was originally adopted in 1975 with a broad commitment to ensure that all children with disabilities would be provided an appropriate education, but with a rigorous screening and evaluation process designed to ensure that only those children who actually needed special education services were made eligible for such services. Subsequent court decisions established the clear legal principle that no child, regardless of the severity or nature of their disability, should be excluded from the benefits of the law. Most recently, Congress and the current administration have passed amendments to the Elementary and Secondary Education Act, embodied in the No Child Left Behind Act, that embrace this principle. We believe that the commitment of "No Child Left Behind" should apply with equal force to children with social, emotional, and/or behavioral challenges. The commitment to education for all children should mean all children. Unfortunately, lack of consistency in diagnostic procedures and criteria among mental health professionals and school personnel creates confusion and conflict in reconciling diagnostic and eligibility decisions in mental health and school settings. Further, uncertainty with respect to where and how children with various mental health problems, such as depression, bipolar disorder, AD/HD, and Tourette syndrome, fit within existing educational disability categories leads to mis-labeling and under-labeling. Finally, the absence of effective early assessment, identification and prevention strategies delays intervention for children at risk and often leads to the presence of more serious problems.

Legislation: Ensure that children with significant social, emotional, and/or behavioral needs, including those with early-onset mental illnesses, remain covered by existing eligibility categories within IDEA.

Recommendation: Establish a multi-disciplinary task force to investigate differing clinical and educational criteria for emotional and behavioral disorders and recommend unified methods and criteria for identifying and assessing disability.

Ensure no cessation of services for all students

IDEA '97 mandated that all children with disabilities who are subject to disciplinary exclusion in excess of ten school days in a school year are entitled to receive those services necessary for them to continue making progress on their IEP goals and objectives, to have access to the general curriculum, and to receive assistance that addresses the behaviors that got them into trouble. Children with disabilities are especially vulnerable to provocation from other students. They often have diminished ability to defend themselves or make appropriate choices in response to challenging situations, and they may display problem behavior as a direct or indirect consequence of their disability. While we recognize that a change in educational placement may be needed in response to problem behavior, we believe that it is counterproductive to respond to such behavior by restricting a child's access to educational services. Instead, we believe that such children are especially in need of ongoing intervention and support that assists them in developing appropriate behavior. This principle is equally applicable for children displaying inappropriate behavior regardless of whether a disability is present. As such, we believe that alternative education, including positive behavioral intervention and support, should be provided on an ongoing basis to all children subject to disciplinary exclusion.

A sixth grader in north Texas was having severe behavioral problems at school that resulted in repeated suspensions and criminal charges. The school was handling him poorly in every respect. They wanted to discipline him rather than provide an accessible environment as required by IDEA. We had ARD meetings with the school that included over 25 district personnel and teams of lawyers, and lasted many hours each (one lasted two days!); all because the district wanted to discipline him rather than provide an accessible environment. Finally, after eight months of fighting and with our threat to go to due process, the principal reversed course and told her district that they should follow our recommendation—that it was the appropriate public education for him. Once they did this, the child's life was turned around. His behavior improved dramatically, and since they implemented our recommendations almost a year ago, there have been no discipline referrals, suspensions, or criminal charges. Without IDEA, he would have ended up in a juvenile detention center. The district was so impressed by the success of this program, they adopted the program permanently and put several other neurologically impaired children in it.

In addition, we urge Congress to maintain the current categories of students who may be placed in alternative educational programs (AEPs). Evidence shows that the disciplinary provisions of IDEA '97 do not significantly limit the ability of administrators to discipline students (U.S. General Accounting Office, 2001). Furthermore, special education students are not given greater leeway in their behavior as a result of IDEA disciplinary provisions (U.S. General Accounting Office, 2001). Finally, research shows that suspension and expulsion are correlated with school dropout, that they are used inconsistently and often in place of a positive climate, that minorities are consistently over represented in school discipline, and that school removal may increase rates of future disruption for some students.

The most effective and promising programs for deterring school violence and chronic disciplinary problems are preventive and comprehensive, and involve parents, students, and the community. Panels of national experts in youth violence prevention have been convened by Congress, the U. S. Departments of Justice and Education, the White House, and the Surgeon General, and have consistently recommended approaches, such as violence prevention, social problem-solving curricula, improved behavior management, mentoring, and restorative justice, that teach students alternatives to violence for solving personal and interpersonal problems.

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The Children's Behavioral Alliance recommends policy that seeks research-based, unified systems of discipline for special and general education. Such systems should be fair and effective, and would meet the "No Child Left Behind" mandate of evidence-based practices.

Legislation: Amend the No Child Left Behind Act to require that all children with social, emotional, and/or behavioral needs, whether formally identified with disabilities or not, be provided positive behavioral intervention and support, including use of Functional Behavioral Assessment and Behavior Intervention Programs.

Legislation: Maintain the existing IDEA '97 requirement for no cessation of services for children with disabilities.

Legislation: Maintain the existing IDEA '97 categories of students who can be placed in Alternative Educational Programs for 45 days.

Legislation: Amend the Elementary and Secondary Education Act to extend the "no cessation of services" requirement to all students and to require provision of positive behavioral intervention to address the problem behavior.

Maintain procedural safeguards

IDEA '97 contains a variety of procedural safeguards designed to strike a careful balance between the need to protect children with disabilities from arbitrary exclusion and the need of administrators to utilize effective and timely action to protect the safety of the students and staff. The General Accounting Office's research (2001) makes clear, contrary to popular belief, that most school administrators feel that the IDEA procedures do not excessively inhibit their ability to take appropriate action in response to problems.

Legislation: Maintain existing IDEA requirements in relation to manifestation determinations and transfer to interim alternative educational settings.

Legislation: Implement procedures consistent with the 2000 National Council on Disability report, *Back to School on Civil Rights*, to assure meaningful monitoring and compliance with and enforcement of IDEA.

Provide critical funding

IDEA requires schools and states to commit substantial resources to meeting the needs of children with disabilities. The original promise of Public Law 94-142 to contribute 40% of the total funding towards the overall cost of special education programming has never been realized. This has inhibited the ability of schools to deliver needed services, but also generated controversy and some hostility towards special education as well as children with disabilities and their families. At the same time, increased funding is urgently needed for research on effective practices and for dissemination of those practices to the field, as well as appropriate training for staff and administrators.

Legislation: Fully fund IDEA at the 40% federal level originally promised by Congress.

Legislation: Maintain non-supplanting provisions to ensure that increased federal funds for special education are used appropriately rather than redirected to general education funding at state and local levels.

Make Parents Meaningful Partners in Planning Individual and System-Wide Programs

> At every level of our re-enrollment back into our local school district, the Director of Special Education and the IEP team really made me feel like I was a part of the TEAM. The IEP and my son's current success is evidence of our meaningful involvement. My feelings are that if you can provide meaningful involvement to families, it is easier for them to buy into the plan, thus helping the child see his upcoming experience as a positive step towards getting back into a more normal environment.

It is widely recognized that behavioral intervention cannot be effective without meaningful collaboration between the parents and the professionals attempting to work with the child. Similarly, it is widely accepted that consumer participation, that is parents and students, is critical in the development of system-wide plans for addressing children's mental health needs. Unfortunately, all too often parents are not allowed to have meaningful participation in the planning and implementation of behavioral intervention strategies for their own child. Similarly, many organizations, when reviewing existing programs or planning new ones, make little effort to include consumers, including parents and/or children, in the assessment and planning process.

> Within one week of our re-enrollment of my 13-year-old son into the Bismarck R-V School District in Missouri, the Director of Special Education set up a training that included me and the local community mental health center. They made it very specific to my son. Everyone wanted to know how to support my son so that he could be successful. Their attitudes will definitely have a positive impact on his success.

Recommendation: Provide funding for joint training of parents and educators on effective strategies for positive behavioral intervention.

Recommendation: Require and fund school-based parent/school/mental health behavioral intervention planning committees.

Recommendation: Provide training to the Parent Training and Information Center on mental health/school services and behavioral assessment and service technologies.

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Summary of Proposed Legislation Cited in this Paper

Legislation: Ensure that children with social, emotional, and/or behavioral problems remain covered by existing eligibility categories within IDEA.

Legislation: Maintain IDEA '97 requirements that provide children with disabilities who also have social, emotional, and/or behavioral needs with positive behavioral intervention and support including use of Functional Behavioral Assessment and Behavior Intervention Programs.

Legislation: Amend IDEA to ensure that Functional Behavioral Assessments and Behavior Intervention Plans, and School-Wide Positive Behavioral Supports are used preventively in response to social, emotional, and/or behavioral problems that have not diminished through the use of standard intervention practices.

Legislation: Maintain the existing IDEA '97 requirement for no cessation of services for children with disabilities.

Legislation: Amend the Elementary and Secondary Education Act to extend the "no cessation of services" requirement to all students and to require provision of positive behavioral supports to address problem behaviors.

Legislation: Maintain existing IDEA requirements in relation to manifestation determinations and transfer to interim alternative educational settings.

Legislation: Maintain the existing IDEA '97 categories of students who can be placed in Alternative Educational Programs for 45 days.

Legislation: Fully fund IDEA at the 40% federal level originally promised by Congress.

Legislation: Maintain non-supplanting provisions to ensure that increased federal funds for special education are used appropriately rather than redirected to general education funding at state and local levels.

Legislation: Implement procedures consistent with the 2000 National Council on Disability report, Back to School on Civil Rights, to assure meaningful monitoring and compliance with and enforcement of IDEA.

Legislation: Require periodic behavioral/mental health screening of all children.

Legislation: Expand IDEA Part D professional development requirements to ensure that all educational and related services staff receive training in positive behavioral supports, functional behavioral assessments, and behavioral intervention planning, and to assure availability within all districts of support staff with more intensive training in such strategies.

Legislation: Amend IDEA to include the "fully-qualified teacher" provisions and timeliness of the No Child Left Behind Act of 2001 in IDEA and apply them to special educators.

Legislation: Increase funding for integrated services among schools, juvenile courts, child welfare, community mental health providers, primary care providers, public recreation agencies, and community-based organizations and tie increases in federal funding to coordinated models of service delivery.

Legislation: Increase federal funding for research and training of educators, mental health professionals and parents to improve interagency cooperation and parent involvement.

Conclusion

IDEA '97 laid the groundwork for the delivery of meaningful services to children with disabilities with significant social, emotional, and/or behavioral needs, including those with early-onset mental illnesses. We, the undersigned organizational endorsers of this paper believe strongly that the provisions of IDEA '97 have not been fully implemented for such children and their families. The implementation of these provisions with integrity is essential in meeting the promise that every child receives a first-class education in America. IDEA '97 was an important step in the right direction, but more needs to be done to assure that schools, communities and families work in effective partnerships to meet the needs of these children who have often misunderstood and underestimated disabilities.

This Paper is adopted and endorsed by the following Organizations/Associations, including those marked with * that have not been part of the CBA:

American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy*
American Psychiatric Association*
Anxiety Disorders Association of America
Bazelon Center for Mental Health Law
Center for the Advancement of Children's Mental Health, Columbia University
Child and Adolescent Bipolar Foundation
Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
Council for Children with Behavioral Disorders
Federation of Families for Children's Mental Health
Learning Disabilities Association of America
National Alliance for the Mentally Ill (NAMI)
National Association for Children's Behavioral Health*
National Association of School Psychologists
National Association of Social Workers*
National Mental Health Association
National Recreation and Park Association*
School Social Work Association of America
Tourette Syndrome Association
Women of Reform Judaism*
Youth Law Center*

References

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th Ed.). Washington, D.C.: Author.

Bower, E.M. (1981). Early identification of emotionally handicapped children in school. (3rd ed.). Springfield, IL: Charles C. Thomas.

Burns, B.J., Costello, E.J., Angold, A., Tweed, D., Stangl, D., Farmer, E.M. & Erklani, A. (1995). Children's mental health service use across service sectors. *Health Affairs* (Millwood), 14, 147-159.

Chesapeake Institute (1994, September). *National agenda for achieving better results for children and youth with serious emotional disturbance.* Washington, D.C.: U.S. Department of Education.

Conroy, M. A., Katsiyannis, A., Clark, D., Gable, R. & Fox, J. M. (2002). State office practices implementing the IDEA disciplinary provisions. *Behavioral Disorders*, 27, 98-108.

Council for Children with Behavioral Disorders. (2000). *Position paper on identification and verification of students with emotional or behavioral disorders.*

Danielson, L. Henderson, K., Schiller, E. (in press). Educational policy – educating children with Attention Deficit Hyperactivity Disorder. In P.S. Jensen, J. Cooper (Eds.), *Attention Deficit Hyperactivity Disorder: State of the Science – Best Practices.* Kingston, NJ: Civic Research Institute.

Dunlap, G., Kern, L., dePerczel, M., Clarke, S., Wilson, D., Childs, K.E., White, R., & Falk, G.D. (1993). Functional analysis of classroom variables for students with emotional and behavioral disorders. *Behavioral Disorders*, 18, 275-291.

Federal Register. (1993, January 21). Washington, DC: U.S. Government Printing Office, 5501.

Federal Register. (1993, February 10). Washington, DC: U.S. Government Printing Office, 7938.

Forness, S.R. & Kavale, K.A. (2001). Ignoring the odds: Hazards of not adding the new medical model to special education decisions. *Behavioral Disorders*, 26, 269-281.

Forness, S.R., & Kavale, K.A. (1997). Defining emotional or behavioral disorders in school and related services. In J. W. Lloyd, E.J. Kameenui, & D. Chard (Eds.), *Issues in educating students with disabilities* (pp. 45-61). Mahwah, NJ: Erlbaum.

Hallenbeck, B.A., & Kauffman, J.M. (1995). How does observational learning affect the behavior of students with emotional or behavioral disorders? A review of research. *Journal of Special Education*, 29, 43-71.

Horner, R.H., Sugai, G., Lewis-Palmer, T., & Todd, A.W. (2001). Teaching school-wide behavioral expectations. *Report on Emotional and Behavioral Disorders in Youth*, 1, 77-79, 93-96.

Hunter, L. (2002). *School-Based Interventions for Attention Deficit and Disruptive Behavior Disorders: A Critical Review.* Report prepared for the Klingenstein Third Generation Foundation, New York, NY.

Kauffman, J.M. (1997). *Characteristics of Children's Behavior Disorders* (6th ed.). Columbus, OH: Merrill.

Knitnet, J., Sternberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems.* New York: Bank Street College of Education Press.

Koyanagi, C., & Gaines, S. (1993). *All systems failure: An examination of the results of neglecting the needs of children with serious emotional disturbance.* Alexandria, VA: National Mental Health Association.

Leaf, P.J, Alegria, M., Cohen, P., Goodman, S.H. (1996). Mental health service use in the community and schools: Results from the four-community MECA study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 889-897.

Lloyd, J.W., Forness, S.R., & Kavale, K.A. (1998). Some methods are more effective than others. *Intervention in School and Clinic*, 33, 195-200.

MTA Cooperative Group. (1999). A 14-Month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry*, 56, 1073-1086.

Munk, D.D., & Repp, A.C. (1994). The relationship between instructional variables and problem behavior: A review. *Exceptional Children*, 60, 390-401.

National Alliance for the Mentally Ill. (2002, February 25). *Comments to the U.S. Department of Education on the Reauthorization of the Individuals with Disabilities Education Act*. Baltimore, MD: Author.

Office of the Surgeon General. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Office of the Surgeon General. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services.

Reid, R. & Nelson, J. R. (2002). The utility, acceptability, and practicality of functional behavioral assessment for students with high incidence problem behaviors. *Remedial and Special Education*, 23, 15-23.

Rosenberg, M.S., Wilson, R., Maheady, L., & Sindelar, P.T. (1997). *Educating students with behavior disorders* (2nd ed.). Boston: Allyn and Bacon.

Scheuermann, B. (1998). Introduction to the special issue on curricular and instructional recommendations for students with emotional/behavioral disorders. *Beyond Behavior*, 9, 3-4.

Scruggs, T.E., & Mastropieri, M.A. (1986). Academic characteristics of behaviorally disordered and learning disabled students. *Behavioral Disorders*, 11, 184-190.

Smith, C.R. (2000). Behavioral and discipline provisions of IDEA 97: Implicit competencies yet to be confirmed. *Exceptional Children*, 66, 403-412.

Sugai, G., Horner, R.H., Dunlap, G., Hieneman, M. Lewis, T.J., Nelson, C.M., Scott, T., Liaupsin, C., Sailor, W., Turnbull, A.P., Turnbull, H.R., III, Wickham, D., Reuf, M., & Wilcox., B. (2000). Applying positive behavioral support and functional behavioral assessment in schools. *Journal of Positive Behavioral Interventions*, 2, 131-143.

U.S. Department of Education (1998). *Twentieth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*. Washington, D.C.: Author.

U.S. General Accounting Office (2001). Report to the Committees on Appropriations, U.S. Senate and House of Representatives: Student Discipline, Individuals with Disabilities Education Act (GAO-01-210). Washington, DC: U.S. Government Printing Office.

Valdes, K.A., Williamson, C.L., & Wagner, M. (1990). *The national longitudinal transition study of special education students*. Vol. 3: Youth categorized as emotionally disturbed. Palo Alto, CA: SRI International.

Walker, H.M., & Fabre, T.R. (1987). Assessment of behavior disorders in the school setting: Issues, problems and strategies revisited. In N.G. Haring (Ed.), *Assessing and managing behavioral disabilities* (pp. 198-243). Seattle: University of Washington Press.

Walker, H.M. & Sprague, J. (1999). The path to school failure, delinquency, and violence: Causal factors and potential solutions. *Intervention in School and Clinic*, 35, 67-73.

Wehby, J.H., Symons, F.J., Canale, J.A., & Go, F.J. (1998). Teaching practices in classrooms for students with emotional and behavioral disorders: Discrepancies between recommendations and observations. *Behavioral Disorders*, 24, 51-56.

Weissman, M.M., Wolk S., Goldstein R.B., Moreau D., Adams P., Greenwald S., Klier C.M., Ryan N.D., Dahl R.E., Wickramaratne P. (1999). Depressed adolescents grown up. *Journal of the American Medical Association*, 281, 1707-1713.

Weisz, J.R., Jensen, P.S. (1999). Efficacy and Effectiveness of Psychotherapy and Pharmacotherapy with Children and Adolescents. *Mental Health Services Research*, 1, 125-158.

In the Best Interests of All

A Position Paper of the
Children's Behavioral Alliance

For more information, please contact CHADD
www.CHADD.org
1-800-233-4050
8181 Professional Place, Suite 150
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